TEXAS TECH UNIVERSITY
HEALTH SCIENCES CENTER™

Ambulatory Clinic Policy and Procedure

Title:	**Student Guidelines for Patient Care**	Policy Number:	**9.10**
		Version Number	**4**
Regulation Reference:	**The Joint Commission, HR.01.02.07**	Effective Date:	**10/2016**
		Original Approval:	**8/2001**

POLICY STATEMENT:

It is the policy of Texas Tech University Health Sciences Center (TTUHSC) Ambulatory Clinics to ensure quality of patient care and protection of patient rights while enabling students to participate in appropriate learning experiences in the TTUHSC Ambulatory Clinics.

SCOPE:

This policy applies to all TTUHSC Ambulatory Clinics operated through its Schools.

PROCEDURE:

1. **Medical Students (MS)** – The following guidelines will apply to medical students' participation in appropriate learning experiences.

    a. MS may see patients under the supervision of an attending physician or resident. (The broad definition of supervision is used)

    b. MS may have access to specific patient records, x-rays, and lab results as assigned by attending physicians or resident. All MS will observe HIPAA regulations as they apply to disclosure of PHI.

    c. When MS are in the clinics, they will be in appropriate professional attire and be identifiable as students with name badges issued by their school which clearly identifies the individual as a TTUHSC MS.

    d. First and second year MS may observe patient care activities with the permission of the attending physician and participate in patient care activities if they are directly associated with the early clinical experience course.

    e. Third and fourth year MS may perform diagnostic and therapeutic procedures with the permission and supervision of the attending physician and/or resident as part of their regular teaching program.

    f. Orders written by MS will not be honored by the nursing unit or ancillary personnel unless countersigned by a resident or attending physician.

    g. All physical examinations performed by a MS involving sensitive areas such as the breast, pelvis, rectum or genitals shall only be performed with a resident or faculty in the room.

    h. The MS' documentation of history of present illness, physical examination and medical decision making are used solely for educational purposes. The MS' documentation shall be saved under the "Medical Student Clinic Note" note type and will not be released as part of the medical record.

    i. MS will not be used as scribes for items such as history of present illness, physical examination and medical decision making since this does not enhance the learning experience.

    j. Only services provided by a faculty member may be used for billing.

k. Attending physicians, residents or other providers may pull forward the MS documentation of chief complaint, review of systems, past medical family/social history for billing purposes after their review of these notes, comment and signature.

l. Professional staff members may correct entries made by MS or modify by adding an addendum.

2. Nursing Students

a. Nursing Students may interact with patients under the supervision of a licensed nurse.

b. Students may have access to patient information as warranted and permitted by preceptor.

c. Students will be in proper dress and identifiable as students.

d. Nursing students may only document using their assigned EHR log-in.

3. Speech Pathology (SLP) and Audiology Students (AuD) – The following guidelines will apply to health professions students' participation in appropriate learning experiences:

a. SLP & AuD students enrolled in clinical courses may interact with patients under the supervision of their assigned preceptor. The level of interaction with patients will be commiserate with clinical skill level as determined by their preceptor and per guidelines set by 3rd party payers.

b. SLP & AuD students may have access to specific patient records as necessary for patient care. All HPS will observe HIPAA regulations as they apply to disclosure of PHI.

c. When SLP and AuD students are in the clinics, they will be in appropriate professional attire and be identifiable as students with name badges issued by their school which clearly identifies the individual as a TTUHSC Health Professional Student.

d. Any student documentation of the above clinic activities performed under direct supervision is used solely for educational purposes. This documentation may be used in the patient medical record only if performed under direct supervision by a designated preceptor, is reviewed by the preceptor, and used as part of that preceptor's documentation of their clinical intervention.

e. Students may document non-patient care events in the patient chart such as phone calls and sending of reports.

f. Only services provided by a licensed and certified provider may be used for billing.

4. Physician Assistant Students (PA) – The following guidelines will apply to medical students' participation in appropriate learning experiences.

a. PA Students may see patients under the supervision of an attending physician, midlevel provider or resident. (The broad definition of supervision is used.)

b. PA Students may have access to specific patient records, x-rays, and lab results as assigned by attending physicians or resident. All PA Students will observe HIPAA regulations as they apply to disclosure of PHI.

c. When PA Students are in the clinics, they will be in appropriate professional and be identifiable as students with name badges issued by their school which clearly identifies the individual as a TTUHSC PA Student.

d. PA Students may perform diagnostic and therapeutic procedures with the permission and supervision of the attending physician, midlevel provider and/or resident as part of their regular teaching program.

e. Orders written by PA Students will not be honored by the nursing unit or ancillary personnel unless countersigned by a resident or attending physician.

f. All physical examinations performed by a PA Student of sensitive areas such as the breast, pelvis, rectum or genitals shall only be performed with a resident or faculty in the room.

g. The PA student's documentation of history of present illness, physical examination and medical decision making are used solely for educational purposes. The PA Student's documentation shall be saved under the "Medical Student Clinic Note" note type and will not be released as part of the medical record.

h. PA Students will not be used as scribes for items such as history of present illness, physical examination and medical decision making since this does not enhance the learning experience.

i. Only services provided by a faculty member may be used for billing. Billing is done for services of the faculty member only. Attending physicians, residents or other non-physician providers may pull forward the reference PA student documentation of chief complaint, review of systems, past medical family/social history for billing purposes after their review of these notes, comment and signature.

j. Professional staff members may correct entries made by PA students or modify by adding an addendum.

5. **Pharmacy Students (PS)** – The following guidelines will apply to pharmacy students' participation in appropriate learning experiences.

   a. PS may see patients under the supervision of their assigned preceptor. (The broad definition of supervision is used.)

   b. PS may have access to specific patient records, x-rays, and lab results as assigned by their pharmacy preceptor. All MS will observe HIPAA regulations as they apply to disclosure of PHI.

   c. When PS are in the clinics, they will be in appropriate professional attire and be identifiable as pharmacy students with name badges issued by their school which clearly identifies the individual as a TTUHSC PS.

   d. PS may observe patient care activities with the permission of the assigned preceptor and participate in patient care activities if they are directly associated with their experiential course. Such activities include but are not limited to: taking medication histories, reconciling medication profiles, counselling patients on their disease states and medications, performing physical assessment, and recommending appropriate therapeutic interventions.

   e. Any PS documentation of the above activities performed under indirect supervision is used solely for educational purposes. PS documentation may be used in the patient medical record only if performed under direct supervision by a pharmacy preceptor, is reviewed by the preceptor, and used as part of that preceptor's documentation of their clinical intervention.

APPROVAL AUTHORITY:

This policy shall be recommended for approval by the Joint Ambulatory Policy Committee to the Council of Deans.

RESPONSIBILITY AND REVISIONS:

It is the responsibility of the Joint Ambulatory Policy Committee to review and initiate necessary revisions based on collaboration and input by and through Quality Improvement/Performance Improvement, Risk Management and the Office of Institutional Compliance.

RIGHT TO CHANGE POLICY:

TTUHSC reserves the right to interpret, change, modify, amend or rescind this policy in whole or in part at any time to reflect changes in policy and/or law.

CERTIFICATION:

This policy was approved by the Council of Deans on October 6, 2016.